C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Oirector DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

November 3, 2010

Russell McCoy, Administrator Rulon House 415 South Arthur Pocatello, ID 83204

RE: Rulon House, Provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Rulon House, which was conducted on October 21, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- Identify the person or discipline responsible for monitoring the changes in the system to
 ensure compliance is achieved and maintained. This is to include how the monitoring
 will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

Russell McCoy, Administrator November 3, 2010 Page 2 of 2

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **November 15, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by November 15, 2010. If a request for informal dispute resolution is received after November 15, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

BARBARA DERN Health Facility Surveyor

Non-Long Term Care

NICOLE WISENOR

Co-Supervisor

Non-Long Term Care

NICOLE WISENOR/srm

Enclosures

November 12, 2010

Ms. Nicole Wisenor, Supervisor Non-Long Term Care Department of Health and Welfare Division of Medicaid Bureau of Facility Standards P. O. Box 83720 Boise, ID 83720-0036 RECEIVED

NOV 15 2010

FACILITY STANDARDS

Dear Ms. Wisenor:

Please find enclosed the completed STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION for Rulon House Group Home from the survey completed October 21, 2010. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely.

Russell C. McCoy, M.A. Ed.

Executive Director

Enclosures

PRINTED: 11/01/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		13G020	B, WIN	1G _		10/2	1/2010
NAME OF F	PROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	TS (W	000			
	annual recertification	· ·					
	The survey was co Barbara Dern, QMI Monica Nielsen, QI	RP, Team Leader			RECEIVE	D	
	Common abbreviat report are: ATS - Active Treatr	ions/symbols used in this ment Specialist			NOV 1 5 2010		
	BMP - Behavior Ma DOP - Destruction IPP - Individual Pro QMRP - Qualified M Professional	gram Plan			FACILITY STANDARI	OS	
W 159			W	159	W159 483.430(a)		***************************************
	integrated, coordinate	treatment program must be ated and monitored by a ardation professional.			All formal programs in place resident will have a measurable in the annual IPP report. Consideration objectives/programs will continued in addendums. The Foregram Director will review.	e objective hanges to nue to be Residential	
	Based on observati interviews it was de	s not met as evidenced by: ions, record review, and staff etermined the facility failed to provided sufficient monitoring			reports for objective accurance appropriateness.		
	and coordination w individuals (Individu the potential to imp	hich directly impacted 4 of 4 lals #1 - #4) reviewed, and had act 8 of 8 individuals			Refer to W210 Refer to W214 Refer to W227 Refer to W231		
	failure resulted in ir necessary assessn) residing in the facility. That adviduals not receiving the nents, training, and monitoring eir needs. The findings			Refer to W232 Refer to W239 Refer to W259 Refer to W289		
		ear old male diagnosed with			Corrective Action Completic December 21, 2010	on Date:	
ABORATOR	Y DIRECTOR'S OBSTROVE	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	,	TITLE	-	(X6) DATE

Any deficiency statement ending with an asterisk of denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		13G020	B. WIN	IG		10/21/2010	
NAME OF P	ROVIDER OR SUPPLIER		'	23	EET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 159	severe mental retar of formal objectives levels. Examples in to, the following: a. "Given training a [Individual #3] will in standing in front of monthly cumulative independence for 3 Jan 2011." No crite b. "Given training a [Individual #3] will in touching the refrige cumulative prompt 3 of 4 consecutive in criteria level was identification." Given training a [Individual #3] will phis left hand into a cumulative prompt 3 of 4 consecutive in criteria level was identification. When asked, the Quinterview on 10/21/	dation. His IPP included a list of that did not include criteria included, but were not limited and at least 8 trials per month, indicate he needs a drink by the sink, with a minimum prompt score of: % of 4 consecutive months by eria level was identified. Indicate he is hungry by rator, with a minimum monthly score of: % independence for months by Jan 2011." No entified. Indicate the istrials per month, resent [sic] with a shirt will put shirt, with a minimum monthly score of: % independence for months by Jan 2011." No entified. IMRP stated during an 10 from 8:30 a.m 12:10	W *	159	Person Responsible: Ryan Qualified Mental Retardation Pro	Shelton, ofessional lesidential	
	not in the IPP. 2. Individual #4's IP a 51 year old male retardation. His IPI objectives that did rexamples included following:	P, dated 8/24/10, documented diagnosed severe mental included a list of formal not include criteria levels.		i Andreijan			
	a. "Given training a	nd at least 8 trials per month,					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		13G020	B, WI	NG _		10/21/2010	
NAME OF P	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 1369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	[Individual #4] will getoothpaste & put to month [sic] cumula consecutive month level was identified b. "Given training a [Individual #4] will gethey get home, with score of: [sic] for 3 8/2011." No criteric. "Given Training month, [Individual food choice when minimum monthly 4 consecutive month level was identified. When asked, the Ginterview on 10/21 p.m., the objective 2. Refer to W210 a failure to ensure the assessments were admission. 3. Refer to W214 a failure to ensure the assessments were admission. 4. Refer to W227 a failure to ensure the were developed to 5. Refer to W231 a failure to ensure the were developed to 5. Refer to W231 a failure to ensure the were developed to 5. Refer to W231 a failure to ensure the were developed to 5. Refer to W231 a failure to ensure the second consumer the second consume	get a toothbrush, apply bothbrush into mouth, with a lative score of: % for 3 of 4 is by Aug 2011." No criteria it. and at least 8 trials per month, give receipt to Staff [sic] when he a month [sic] cumulative of 4 consecutive months by a level was identified. [sic] and at least 8 trials per #4] will select a health [sic] given two choices with a cumulative score of: % for 3 of of this by 9/2011." No criteria it. QMRP stated during an /10 from 8:30 a.m 12:10 s were not measurable. as it related to the facility's are QMRP ensured vocational excompleted within 30 days of except a comprehensive. as it relates to the facility's are QMRP ensured behavioral excomprehensive. as it relates to the facility's are QMRP ensured objectives address individuals' needs.	W	159			
		measurable terms.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			
		13G020	B. WING		10/21/2010	
NAME OF P	ROVIDER OR SUPPLIER		2:	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	Continued From pa	ge 3	W 159			
	failure to ensure the	s it relates to the facility's e QMRP ensured objectives sed on individuals' functional				
	failure to ensure the replacement plans	s it relates to the facility's e QMRP ensured the for individuals' maladaptive eloped to meet their behavioral				
	7. Refer to W259 as it relates to the facility's failure to ensure the QMRP ensured comprehensive functional assessments were reviewed for relevancy and were accurate.					
	failure to ensure the techniques used to	s it relates to the facility's e QMRP ensured that manage inappropriate rporated into the program				
W 210	,	VIDUAL PROGRAM PLAN	W 210	W210 483.440(c)(3)		
	assessments or reasonable supplement the pre	r admission, the m must perform accurate assessments as needed to liminary evaluation conducted		The Vocational Assessment will to the admission assessments completion within the first thirty of	packet for	
	prior to admission.			Corrective Action Completic December 21, 2010	on Date:	
	Based on record red determined the factors assessments were admission for 1 of admitted to the factors.	s not met as evidenced by: eview and staff interview, it was flity failed to ensure conducted within 30 days of individual (Individual #1) lity within the last year. This f information being available		Person Responsible: Jamie L. Residential Program Director	Anthony,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		13G020	B. WING		10/21	/2010
NAME OF P	ROVIDER OR SUPPLIER		2:	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 214	on which to base very The findings included the facility on 11/18. His record included which was dated 3 assessment was nadmission. When asked about during an interview 12:10 p.m., he did was not completed. The facility failed to Vocational Assess days of admission. The comprehensive identify the client's behavioral manage. This STANDARD Based on record redetermined the fact assessments continformation for 2 or and #4) whose believely weed. This reson which to base previewed. The findings included the findings in f	ocational program decisions. le: PP, dated 12/15/09, year old male diagnosed with rdation. He was admitted to 8/09. d a Vocational Assessment /16/10. His vocational ot completed within 30 days of the delay, the QMRP stated on 10/21/10 from 8:30 a.m not know why the assessment within 30 days of admission. Densure Individual #3's ment was completed within 30 MDIVIDUAL PROGRAM PLAN are functional assessment must specific developmental and ement needs. Is not met as evidenced by: Eview and staff interview, it was stility failed to ensure behavioral and comprehensive of 4 individuals (Individuals #1 navior assessments were sulted in a lack of information program intervention decisions.	W 214	W214 483.440(c)(3)(iii) For Individual #1 and 4, the fanalysis of Behavior will be addressing the concerns writte citation documentation. The fuse the new revised the functional Analysis of Behavior to obtain more accurate informanew forms will be used in the furnal individual requires an assupdate. In addition, a revised will be used in assessing modifying behaviors that will e information from direct care staff	e re-done en in the facility will forms for r in order ation. The ture when ssessment ABC form new or elicit more	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		13G020	B. WING		10/21/2010
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLÉTION
W 214	Individual #1's BMF engaged in non-correfusing to take par However, his Funct dated 8/9/10, did non-compliance be When asked, the Quinterview on 10/21/1 p.m., the behavior a revised. 2. Individual #4's IP a 51 year old male retardation. Individual #4's BMF engaged in self injurusing objects to hardoors, banging on withrowing objects), a kicking and biting opersonal belonging items), and elopem facility without staff;	ear old male diagnosed with etardation and autism. P, dated 6/19/10, stated he impliance which was defined as it in a task. Ional Assessment of Behavior, ot identify or assess his havior. IMRP stated during an 10 from 8:30 a.m 12:10 assessment needed to be P, dated 8/24/10, documented diagnosed severe mental P, dated 1/20/10, stated he incous behavior (defined as immoself), DOP (slamming walls and windows, and assault (defined as hitting, thers), stealing (taking others's), pica (ingesting non-food ent (defined as leaving the behavior, it identify or assess his DOP	W 214	Corrective Action Completi December 21, 2010 Person Responsible: Ryan Qualified Mental Retardation P	n Shelton,
	interview on 10/21/	MRP stated during an 10 from 8:30 a.m 12:10 assessment needed to be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		13G020	B. WI	NG		10/21	1/2010
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 214 W 232	Continued From parthe facility failed to Individual #4's behasufficiently develop 483.440(c)(4)(iv) IN The objectives of the must be organized progression appropriate determined the facilities and were established by abilities and were experience success for 3 of 4 individual whose IPPs and proviewed. This restraining on objective without their rate of abilities being taken findings include: 1. Individual #1's IF documented a 18 y moderate mental results.	age 6 be ensure Individual #1 and avioral assessments were ed. IDIVIDUAL PROGRAM PLAN the individual program plan to reflect a developmental priate to the individual. Is not met as evidenced by: Eview and staff interview, it was assed on individuals' functional designed to allow individuals to a in achieving those objectives as (Individuals #1, #2, and #4) ogram summaries were ulted in individuals receiving the start of the interview, and in into consideration. The interview is placed to the interview of the i	W	214	W232 483.440(c)(4)(iv) The objectives will be reaccurately reflect current abilities. Future objectives will to display goal numbers slightly current abilities. Modification made as improvements or de observed. The Residential Director will review object appropriateness and accurate quarterly basis. Corrective Action Completic December 21, 2010	evised to functional be written above the swill be clines are Program tives for cy on a con Date: Shelton, ofessional	
	of functioning. Exalimited to, the followa. His objective for was set at a month 5 of 6 consecutive	as set below his current level imples included, but were not ving: responding to "yes" questions ly cumulative score of 65% for months. His QMRP if the following status of the		A THEORYTON			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G020	B. WII	NG_		10/21/2010	
NAME OF F	ROVIDER OR SUPPLIER			23	EET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLÉTION DATE
W 232	- 2/10: 100% - 3/10: 91% - 4/10: 93% - 5/10: 100% - 6/10: 87% - 7/10: 79% - 8/10: 85% Individual #1's obje based on his function b. His objective for was set at a month 5 of 6 consecutive summaries showed objective: - 1/10: 93% - 2/10: 80% - 3/10: 91% - 4/10: 100% - 5/10: 100% - 6/10: 84% - 7/10: 74% - 8/10: 83% Individual #1's obje based on his function c. His objective for cumulative score of months. His QMRI following status of 11/10: 100% - 2/10: 100% - 2/10: 100% - 3/10: 99% - 4/10: 83% - 5/10: 100% - 6/10: 91% - 7/10: 84% - 8/10: 91%	ctive was not established onal abilities. responding to "no" questions ly cumulative score of 70% for months. His QMRP of the following status of the sective was not established onal abilities. eating was set at a monthly of 45% for 5 of 6 consecutive properties.	W	232			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDII		LE CONSTRUCTION	COMPLETED		
		13G020	B. WIN	IG		10/2	1/2010
NAME OF F	PROVIDER OR SUPPLIER			23	EET ADDRESS, CITY, STATE, ZIP CODE 69 RULON DCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 232	interview on 10/21/p.m., he did not loo objectives needed of 2. Individual #2's IP a 25 year old femal mental retardation. Her QMRP summa showed objective of current level of fund but were not limited a. Her objective for teeth was set at a conscrept of 35% for 3 QMRP summaries the objective: - 1/10: 31% - 2/10: 64% - 3/10: 74% - 4/10: 37% - 5/10: 91%"MEt [siden of conscrept of teeth was set at a conscrept of the conscrept of teeth was set at a conscrept of the conscript	MRP stated during an 10 from 8:30 a.m 12:10 k at the numbers and the to be revised. PP, dated 3/3/10, documented the diagnosed with profound tries, dated 1/10 - 8/10, riteria was set below her exting. Examples included, at to, the following: allowing staff to re-brush her cumulative monthly prompt of 4 consecutive months. Her showed the following status of th	W	232			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G020	B, WII	√G_		10/21/2010	
NAME OF P	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 232	- 1/10: 48% - 2/10: 81% - 3/10: 70% - 4/10: 91% - 5/10: 90%; criteria - 6/10: 86% - 7/10: 71% - 8/10: 53% The 5/10 revision of criteria to 20%. Ho already met and extendividual #2's objective for was set at a cumula 15% for 3 of 4 consistent summaries showed objective: - 1/10: 30% - 2/10: 25% - 3/10: 25% - 3/10: 29% - 4/10: 22% - 5/10: 34% - 6/10: 37% - 7/10: 22% - 8/10: 19% Individual #2's objective on 10/21/p.m., he did not loo objectives needed in 3. Individual #4's IP	onsisted to increasing the wever, Individual #2 had ceeded the 20% criteria. ctive was not established onal abilities. touching her pants when wet ative monthly prompt score of secutive months. Her QMRP I the following status of the ctive was not established onal abilities. MRP stated during an 10 from 8:30 a.m 12:10 k at the numbers and the	W	232			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13G020	B. WING _		40/04/0040	
NAME OF P	ROVIDER OR SUPPLIER	133020	STR	EET ADDRESS, CITY, STATE, ZIP CODE	10/2	1/2010
RULON I	HOUSE		2	369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 232	His QMRP summar objective criteria was of functioning. Exalimited to, the follows a. His objective for monthly cumulative consecutive months showed the following - 1/10: 98% - 2/10: 93% - 3/10: 95% - 4/10: 80% - 5/10: 82% - 6/10: 54% - 7/10: 63% Individual #4's objective for set at a monthly curly dependent of the following - 1/10: 64% - 2/10: 87% - 3/10: 93% - 4/10: 89% - 5/10: 77% - 6/10: 86% - 7/10: 71% - 8/10: 95% Individual #4's objective for set at a monthly curly consecutive months of the following - 1/10: 64% - 2/10: 87% - 3/10: 95% - 1/10: 71% - 8/10: 95% Individual #4's objective for curly consecutive for set at a monthly curly consecutive months of the following - 1/10: 64% - 2/10: 87% - 3/10: 95% Individual #4's objective for curly consecutive for curly curl	ctive was not established and abilities. Social Meal Preparation was set at a score of 42% for 3 of 4 st. His QMRP summaries and abilities. Social Meal Preparation was mulative score of 35% for 3 of this. His QMRP summaries and abilities are status of the objective:	W 232	DEFICIENCY)		
	of 4 consecutive me	score of 42% accuracy for 3 onths. His QMRP summaries ag status of the objective:				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		13G020	B. WIN	G	10/21	1/2010
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
W 232	- 2/10: 77% - 3/10: 54% - 4/10: 67% - 5/10: 66% - 6/10: 78% - 7/10: 90% - 8/10: 94% Individual #4's objectives on 10/21/p.m., he did not loo objectives needed to the facilities. The facility failed to established based on abilities. 483.440(f)(1)(i) PRCCHANGE The individual progleast by the qualified professional and rebut not limited to sit successfully completed in the individuals #1, #2, program summaried resulted in individuals #1, #2,	ctive was not established onal abilities. MRP stated during an 10 from 8:30 a.m 12:10 k at the numbers and the o be revised. ensure objectives were on individuals' functional DGRAM MONITORING & ram plan must be reviewed at d mental retardation vised as necessary, including, uations in which the client has eted an objective or objectives vidual program plan. s not met as evidenced by: view and staff interview, it was lity failed to ensure IPPs were ate for 3 of 4 individuals and #4) whose IPPs and is were reviewed. This als continuing to receive formal es they had successfully	W 2	W255 483.440(f)(1)(i) The objectives will be reaccurately reflect current abilities. Future objectives will to display goal numbers slightly current abilities. Modification made as improvements or de observed. The Residential Director will review object appropriateness and accura quarterly basis. Corrective Action Completi December 21, 2010	functional be written above the as will be eclines are Program ctives for acy on a on Date: Shelton, rofessional	

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/01/2010 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	G	COMPLE	IED
		13G020	B, WIN	G_		10/2	1/2010
NAME OF P	ROVIDER OR SUPPLIER			23	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE
W 255	1. Individual #1's IP documented a 18 ymoderate mental remoderate	P, dated 12/15/09, ear old male diagnosed with stardation and autism. ries, dated 1/10 - 9/10, showed as set below his current level emples included, but were not ving: responding to "yes" questions y cumulative score of 65% for	W2	255			

(X2) MULTIPLE CONSTRUCTION

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	IULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
VIAD LEVIA	O CORRECTION	IDENTIFICATION NOMBER.	A. BUI	LDIN	NG	JOHN EETEB	
		13G020	B. WIN	NG_	***************************************	10/2	1/2010
NAME OF F	PROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 255	his progress. c. His objective for cumulative score of months. His QMRF following status of the state of the	eating was set at a monthly f 45% for 5 of 6 consecutive summaries showed the he objective: ctive was not revised based MRP stated during an 10 from 8:30 a.m 12:10 k at the numbers and the to be revised. PP, dated 3/3/10, documented e diagnosed with profound ries, dated 1/10 - 8/10, riteria was set below her ctioning. Examples included,	W	255			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		13G020	B. WING _		10/2	1/2010	
NAME OF F	PROVIDER OR SUPPLIER		2	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON POCATELLO, ID 83201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 255	- 4/10: 37% - 5/10: 91%"MEt [si - 6/10: 56% - 7/10: 62% - 8/10: 70% The 5/10 revision of criteria to 45%. Ho already met and extendividual #2's objective for cumulative monthly 4 consecutive monthly 6 consecutive monthly	onsisted to increasing the wever, Individual #2 had ceeded the 45% criteria. ctive was not revised based sitting in a chair was set at a prompt score of 16% for 3 of ths. Her QMRP summaries ag status of the objective: a was increased to 20% onsisted to increasing the wever, Individual #2 had ceeded the 20% criteria. ctive was not revised based touching her pants when wet ative monthly prompt score of secutive months. Her QMRP I the following status of the	W 255				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		13G020	B. WIN	G		10/2	1/2010
NAME OF F	ROVIDER OR SUPPLIER			23	EET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 255	her progress. When asked, the Clinterview on 10/21/p.m., he did not loo objectives needed if 3. Individual #4's IP a 51 year old male retardation. His QMRP summan objective criteria was of functioning. Exalimited to, the follow a. His objective for monthly cumulative consecutive months showed the followir - 1/10: 98% - 2/10: 93% - 3/10: 95% - 4/10: 80% - 5/10: 82% - 6/10: 54% - 7/10: 63% Individual #4's objective for set at a monthly curulative curulative consecutive months.	ctive was not revised based MRP stated during an 10 from 8:30 a.m 12:10 k at the numbers and the to be revised. P, dated 8/24/10, documented diagnosed with severe mental ries, dated 1/10 - 9/10, showed as set below his current level mples included, but were not	W2				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/01/2010 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		13G020	B. WIN	IG_		10/21	1/2010
NAME OF P	ROVIDER OR SUPPLIER		•	23	EET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 255	- 2/10: 87% - 3/10: 93% - 4/10: 89% - 5/10: 77% - 6/10: 86% - 7/10: 71% - 8/10: 95% Individual #4's obje his progress. c. His objective for monthly cumulative of 4 consecutive meshowed the followir - 1/10: 82% - 2/10: 77% - 3/10: 54% - 4/10: 67% - 5/10: 66% - 6/10: 78% - 7/10: 90% - 8/10: 94% Individual #4's obje his progress.	ge 16 Ctive was not revised based Three Step Task was set at a score of 42% accuracy for 3 onths. His QMRP summaries ag status of the objective:	W 2	255			
	interview on 10/21/	10 from 8:30 a.m 12:10 k at the numbers and the					
W 259	revised based on ir	ensure objectives were ndividuals' progress. GRAM MONITORING &	W 2	259	W259 483.440(f)(2)		
	assessment of eac	ne comprehensive functional h client must be reviewed by team for relevancy and			Assessment will be revised additional space for further ana		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		13G020	B. WI	NG_		10/21	1/2010
NAME OF PROVID				2:	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON POCATELLO, ID 83201		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
This Base dete commercial relevance individual commercial reviet train. The 1. In document with the second commercial reviet train. The 1. In document was accument was accument was accument with the second control of the	ed on record recording the facing prehensive fundamental upday iduals (Individual prehensive fundamental results). This results as findings included a finding, brushing a finding, brushing a finding. IPP included of the comprehensive was a finding a findi	s not met as evidenced by: view and staff interview, it was lity failed to ensure the ctional assessment was erdisciplinary team for ited as necessary for 2 of 4 ials #1 and #4) whose ctional assessments were ulted in individuals receiving sessed as being independent.	W	259	formal programs will be written of the information on the Cl Residential Program Director with the programs and CFA along IPP report each year. Corrective Action Completic December 21, 2010	based off FA. The will review with final on Date: Shelton, rofessional	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	COMPLET	
		13G020	B. WIN	IG_		10/21	1/2010
NAME OF P	ROVIDER OR SUPPLIER			23	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON OCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 259	Functional Assessr	I #4's Comprehensive ment, dated 8/10/10, s independent in the above	W 2	259			
	interview on 10/21/ p.m., the comprehe	MRP stated during an 10 from 8:30 a.m 12:10 ensive functional assessment or relevancy and it was not					
W 289	Individual #4's com assessments were were accurate.	ensure Individual #1 and prehensive functional reviewed for relevancy and IT OF INAPPROPRIATE	tional evancy and				
	The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 2 of 4				Individual #1's Behavior ma program will be revised to in more appropriate interventions he is out in the community. For #2, the behavior management will be revised to incorporate into for her agitation behavior. For individuals in the facility, the	for when Individual to program erventions the other	
					Mental Retardation Profession Residential Program Director with the other charts for appropriate linterventions and make revinecessary. Corrective Action Completic	onal and will review behavioral isions as	
	behavior managem This resulted in a la being in place to er	uals #1 and #2) whose hent programs were reviewed. ack of appropriate interventions hear individuals' behavioral the findings include:			December 21, 2010	Shelton,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUR' COMPLETE	
		13G020	B. WIN	1G		10/2	1/2010
NAME OF P	ROVIDER OR SUPPLIER			23	REET ADDRESS, CITY, STATE, ZIP CODE 369 RULON COCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 289	1. Individual #1's IP documented a 18 y moderate mental research with a staff p When asked, the A Individual #1 and a individual (from and same company) an person working with on 10/20/10 from 1 person reported he in the van on multipulation in the van on between the van on the van on multipulation in the van on multipulation in the van on the	P, dated 12/15/09, ear old male diagnosed with etardation and autism. ion on 10/19/10 from 6:55 - al #1 was noted to leave the erson, in the facility's van. TS, who was present, stated staff were going to pick up an other facility owned by the d take her to school. The staff in Individual #1 was interviewed :25 - 1:40 p.m. The staff and Individual #1 were alone ole occasions. P, dated 6/19/10, documented one to one supervision. One was defined as "staff should ct at all times unless alone in om." did not include instructions to riate protocol to follow when munity in order to ensure ed the necessary supervision. P, dated 3/3/10, documented e diagnosed with profound n objective related to agitation as crying, screaming, g away. dated 8/31/10, did not to staff on what to do if she	W:	289	and Jamie L. Anthony, F	Residential	

	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	COMPLE	
		13G020	B. WIN	1G _		10/2	1/2010
NAME OF P	PROVIDER OR SUPPLIER			:	REET ADDRESS, CITY, STATE, ZIP CODE 2369 RULON POCATELLO, ID 83201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 289	When asked, the Conterview on 10/21/p.m., Individual #2's	MRP stated during an 10 from 8:30 a.m 12:10 s BMP needed to be revised. ensure Individual #1 and #2's	W	289			

PRINTED: 11/01/2010

FORM APPROVED Bureau of Facility Standards STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 13G020 10/21/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **2369 RULON RULON HOUSE** POCATELLO, ID 83201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) MM197 MM197 16.03.11.075.10(d) Written Plans MM197 16.03.11.075.10(d) Is described in written plans that are kept on file Refer to W289 in the facility; and This Rule is not met as evidenced by: Refer to W289. MM380 16.03.11.120.03(a) MM380 16.03.11.120.03(a) Building and Equipment MM380 The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept RECEIVED clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. NOV 15 2010 This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, FACILITY STANDARDS sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: 1. An environmental review was conducted on 10/20/10 from 10:00 - 10:55 a.m. During that time, the following was noted: - Six cloth chairs in the dining room contained The cloth chairs will be cleaned. food debris. The kick plate on the refrigerator will be - The kick plate was missing from the refrigerator replaced. in the kitchen. Individual #1's dresser will be replaced. - Individual #1's dresser had 3 broken drawers, 1

Bureau of Facility Standards

broken cabinet face, and the top was loose.

(X6) DATE

f continuation sheet 1 of 3

Bureau of Facility Standards

Durcau	n racility Standards	·					
AND PLAN OF CORRECTION IDENTIFICATION 13G020		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			G	(X3) DATE SURVEY COMPLETED 10/21/2010	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	STATE, ZIP CODE	1	.,
RULON			2369 RUL		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE	
ММ380	- The walls in Individuage areas of miss - The handle on Indibroken The wall vent in Incontained a build usual to the upstairs hall be behind the toilet was missing. There was urine a section of paint personal the vanity contained. There was urine a shower head. The the vanity contained. There was urine a and the floor behin up of brown matter Individual #4 and #	idual #1's bedroom caing paint. dividual #4's nightstant andividual #4 and #7's up of lint andividual #5's bedroom of lint. around the base of the ast pulling away from the was a 1 inch by 3 including from the wall ab bottom 2 rows of drawd brown matter. around the base of the difference of the toilet contained in the bathroom use	bedroom me toilet in pard the wall. The vanity nech ove the awers of the toilet a build d by	MM380	The walls in Individual #1s will to cover the patches recently report to cover the patches. The wall vent in Individual #4 bedroom will be cleaned. The upstairs hall bathroom will be and baseboards repaired. The restroom in Individual #4 room will be cleaned. Corrective Action Completed December 21, 2010 Person Responsible: Sam Facilities Manager and Jamie L Residential Program Director	and #7's ce cleaned and #7's on Date:	
MM724	16. 0 3. 1 1.270.01(a)) Assesments		MM724	MM724 16.03.11.270.01(a)		
	program implemen provided at entry a by an interdisciplina members drawn fro	vidual program planni station, assessments nd at least annually the ary team composed of om or representing stationar representing stationar case	must be hereafter of uch		Refer to W259		

Bureau of Facility Standards STATE FORM

Refer to W259.

This Rule is not met as evidenced by:

Y54M11

Bureau of Facility Standards

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER: A. BUILDING		IG	(X3) DATE SURVEY COMPLETED			
		13G020		B. WING _		10/2	1/2010
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
RULON	HOUSE		2369 RUL POCATEL	.ON .LO, ID 832	01		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
MM724	Continued From pa	ge 2		MM724			
MM725	implementation of e of care, integrating program, recording initiating periodic re for necessary modi	onsible for supervising each resident's individual the various aspects of each resident's programmer of each individual fications or adjustme ovided by a QMRP ount.	dual plan of the ress and ral plan nts. This	MM725	MM725 16.03.11.270.01(b) Refer to W159 and W232		
MM730	Data			MM730	MM730 16.03.11.270.01(d)(i) Refer to W214		
MM853	Data			MM853	MM853 16.03.11.270.08(b)(i) Refer to W210		

Y54M11